Department:	Medical Management	**Original Approval:**	11/28/2012
Policy #:	MM144	**Last Approval:**	09/26/2018
Title:	Home Oxygen		
Approved By:	UM Committee		

REQUIRED DOCUMENTATION

For initial Oxygen request:

- Completed Form CMS-484 (Certificate of Medical Necessity (CMN): Oxygen) including physician's signature: http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms484.pdf
- Clinical documentation from visit within 1 month of the request, including history exam, diagnosis, assessment and plan
- Arterial blood gas or oxygen saturation at rest and/or with exercise showing saturation less than 89%.
- The conditions under which the blood gas or oxygen saturation are performed must be specified in writing and submitted with the initial claim, (such as, at rest, during exercise, or during sleep.
- When oxygen is prescribed based on an oximetry study obtained during exercise, there must be documentation of three oximetry studies in the member's medical record.
    - Testing at rest without oxygen, and
    - Testing during exercise without oxygen, and
    - Testing during exercise with oxygen applied
- Blood gas studies or oxygen saturation should be done while the patient is in the chronic stable state, not during a period of an acute illness or an exacerbation of their underlying disease.
- Orders signed by the physician, which must include:
    - Prescribed oxygen flow rate
    - Means of delivery (such as mask, nasal cannula)
    - Estimate of the frequency, duration of use (such as 2 liters per minute 10 minutes per hour, 12 hours per day) and duration of need (such as 6 months or lifetime)
    - **NOTE:** A prescription for "Oxygen PRN" or "Oxygen as needed" does not meet this last requirement.

For portable oxygen:

- In addition to the above requirements, medical documentation must show that the patient is mobile and would benefit from the use of a portable oxygen system in the home or outside of the home.

For continuation of oxygen:

- Documentation of a recent follow up clinical visit, including diagnosis, assessment and plan
- Oxygen saturation measurements showing continued need for the oxygen (see above).
- Documentation of benefit of the device to the member

- Completed Form CMS-484 (Certificate of Medical Necessity (CMN): Oxygen) marked Recertification, and including physician's signature. http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms484.pdf
- Orders signed by the physician, which must include:
    - Prescribed oxygen flow rate
    - Means of delivery (such as mask, nasal cannula)
    - Estimate of the frequency, duration of use (such as 2 liters per minute 10 minutes per hour, 12 hours per day) and duration of need (such as 6 months or lifetime)
    - **NOTE:** A prescription for "Oxygen PRN" or "Oxygen as needed" does not meet this last requirement.

For Cluster Headaches (Medicare only):
The documentation must show the history, other treatments tried and the outcomes, diagnosis, assessment and plan, **AND**
CMN and orders as above, **AND**
Details of the CMS approved clinical trial

BACKGROUND
None.

DEFINITIONS
None.

INDICATIONS/CRITERIA

Medicaid Members	***Continue to criteria for approval below.*** Noridian Local Coverage Determination (LCD): Oxygen and Oxygen Equipment (L33797)
Medicare Members	Noridian Local Coverage Determination (LCD): Oxygen and Oxygen Equipment (L33797)

Medicare Members and Apple Health Members:

INDICATIONS/CRITERIA

FOR OXYGEN SYSTEMS (STATIONARY OR PORTABLE), THE FOLLOWING CRITERIA ARE REQUIRED (A-D):

A. The treating physician has determined that the member has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy
B. The member's blood gas study or pulse oximetry reading meets Group I or Group II criteria range stated below when member is tested in the "chronic stable state":

1. **GROUP I CRITERIA**
    - Arterial $PO_2 \leq 55$ mm Hg or pulse oximetry reading ≤ 88% at rest on room air, **OR**
    - An arterial $PO_2 \leq 55$ mm Hg or pulse oximetry reading ≤ 88% taken during sleep for at least 5 minutes for a member who demonstrates an arterial $PO_2 \geq 56$ mm Hg, or pulse oximetry reading ≥ 89 % while awake, **OR**
    - A decrease in arterial $PO_2 > 10$ mm Hg, or a decrease pulse oximetry reading > 5 % from baseline saturation, for at least 5 minutes taken during sleep associated with symptoms or signs reasonably attributable to hypoxemia, **OR**
    - An arterial $PO_2 \leq 55$ mm Hg or pulse oximetry reading ≤ 88%, taken during exercise, for a member who demonstrates an arterial $PO_2 \geq 56$ mm Hg or pulse oximetry reading ≥ 89 % during the day while at rest. In this case, oxygen is provided during exercise if it is documented that the use of oxygen improves the hypoxemia that was demonstrated during exercise on room air.
2. **GROUP II CRITERIA**
    - An arterial PO_2 between 56-59 mm Hg or pulse oximetry reading of 89% at rest, during sleep, or during exercise (as described in Group I) **AND**
    - Any of the following:
        - Dependent edema suggesting congestive heart failure (CHF) **or**
        - Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale on EKG (P wave greater than 3 mm in standard leads II, III, or AVF), **or**
        - Erythrocythemia with a hematocrit > 56%

C. The qualifying blood gas study on room air was obtained under the following conditions:
    - If performed during an inpatient hospital stay, the blood gas must be the one obtained closest to, but no earlier than 2 days prior to the hospital discharge date; OR
    - If the blood gas is not performed during an inpatient hospital stay, it must be performed when member is not having a period of acute illness or an exacerbation of the underlying disease.

D. Alternative treatment methods have been tried or have been considered and deemed clinically ineffective.

PORTABLE OXYGEN SYSTEMS

A portable oxygen system is covered for a member either **by itself**, or, to use **in addition** to a stationary oxygen system if:

E. Request meets COVERAGE INDICATIONS specified in subsections A-D above, as appropriate; **AND**

F. The medical documentation indicates that the patient is mobile in the home and would benefit from the use of a portable oxygen system in the home or outside of the home.

COVERAGE TIMELINE (INITIAL)

1. **GROUP I CRITERIA**

- Initial coverage is limited to 12 months or the physician-specified length of need, whichever is shorter

2. **GROUP II CRITERIA**
   - Initial coverage is limited to 3 months or the physician specified length of need, whichever is shorter.

COVERAGE TIMELINE (RECERTIFICATION)

1. **GROUP I CRITERIA**
   - CHPW will renew authorization for home oxygen requests annually, **for a maximum period of 60 months** with an updated CMN and renewal prescription, provided the clinical criteria continue to be met. Recertification requests, which are limited to one every 12 months, would be applicable from month 13 – 60.

2. **GROUP II CRITERIA**
   - CHPW will require Recertification CMN and renewal prescription **3 months** after Initial Certification and annually thereafter**,** provided the clinical criteria continue to be met.

COVERAGE DENIAL

Oxygen therapy is not considered reasonable and necessary for the following conditions:

- Angina pectoris in the absence of hypoxemia. This condition is generally not the result of a low oxygen level in the blood and there are other preferred treatments.
- Dyspnea without cor pulmonale or evidence of hypoxemia
- Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities but in the absence of systemic hypoxemia. There is no evidence that increased PO_2 will improve the oxygenation of tissues with impaired circulation.
- Terminal illnesses that do not affect the respiratory system

SPECIAL CONSIDERATIONS

PORTABLE OXYGEN SYSTEMS

A portable oxygen system is covered for a member either **by itself**, or, to use **in addition** to a stationary oxygen system if:

- Request meets COVERAGE INDICATION specified in subsections A-D above, as appropriate; **AND**
- The medical documentation indicates that the patient is mobile in the home and would benefit from the use of a portable oxygen system in the home or outside of the home.

HOME USE OF OXYGEN FOR CLUSTER HEADACHES (CH) FOR MEDICARE MEMBERS ONLY

MEDICARE Members who enrolled in a clinical trial on or after January 4, 2011 that was approved by CMS are covered for home oxygen for CH.
Please refer to 240.2.2 – Home Oxygen Use to Treat Cluster Headache (CH) – (Effective January 4, 2011) (Rev. 130, Issued: 01-14-11, Effective: 01-04-11, Implementation: 02-15-11) for specific coverage information.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part4.pdf (Accessed October 12, 2017)

Oxygen is not covered for cluster headaches for Apple Health Members.

HOME USE OF OXYGEN CONCURRENT WITH CPAP/BiPAP

Some members may require the use of home oxygen therapy along with a PAP device.

- These members must meet requirements for both therapies (PAP criteria listed in MM135 and home oxygen
- To demonstrate member qualifies for oxygen therapy, pulse oximetry values must be obtained during the titration portion of the polysomnography, when the OSA has been sufficiently treated such that the underlying severe lung disease is unmasked

OTHER CONDITIONS

For all other specifics of coverage including repair and replacement of equipment CHPW will follow: Noridian Local Coverage Determination (LCD): Oxygen and Oxygen Equipment (L33797)

LIMITATIONS/EXCLUSIONS

Please refer to a product line's certificate of coverage for benefit limitations and exclusions for these services:

PRODUCT LINE	LINK TO CERTIFICATE OF COVERAGE
MEDICARE ADVANTAGE	http://healthfirst.chpw.org/for-members/resource-library/handbooks-and-guides
WASHINGTON APPLE HEALTH	http://chpw.org/our-plans/apple-health/
INTEGRATED MANAGED CARE	http://chpw.org/our-plans/apple-health/

Citations & References

CFR		
WAC		
RCW		
Contract Citation	☒ WAH	
	☒ IMC	

	☒ MA	Noridian Local Coverage Determination (LCD): Oxygen and Oxygen Equipment (L33797)
Other Requirements		
NCQA Elements	UM2	

Revision History

Revision Date	Revision Description	Revision Made By
11/28/2012	Original Approval	MMLT
01/10/2014	Criteria revised; maximum 5 year approval added to comply with CMS requirements; benefit references updated	MMLT
01/28/2015	Approval	MMLT
03/04/2016	References and links checked	Kate Brostoff, MD
03/01/2017	Minor editing and links checked	Cyndi Stilson, RN
03/01/2017	Approval	MMLT
10/13/2017	Changes to include criteria revised to include annual recertification up to a maximum of 5 years, indications for criteria approval, special considerations and denial indications included.	Sheila Ranganathan RN
10/13/2017	Approved	LuAnn Chen, MD
10/16/2017	Approval	MMLT
03/27/2018	Changed from UM021	Cindy Bush
04/23/2018	Transferred to new template	Cindy Bush
09/04/2018	Removed reference to the NCD 240.2 other than for cluster headaches for MA members. Listed required documentation. Removed reference to PA and duplicate reference to the benefit grid. Specified that both orders and CMN are required for initial and continuation requests. Moved portable oxygen criteria from special considerations to indications/criteria. Clarified that oxygen is not covered for CH for AH members.	LuAnn Chen, MD
09/20/2018	Approved	UM Medical Subcommittee
09/26/2018	Approved	UM Committee